Indiana State Department of Health Laboratory
West Nile Dead Bird Submission
SF 50534 (R/6-02)

We are asking for submission of dead birds (limited to crows, blue jays, raptors and exotic birds). See reverse side for instructions.

Person Completing Form:

Name:_____ Phone #: (____)_____

Organization:_____

Person Reporting Dead Bird(s):

Name:_____ Phone #: (____)_____

Date of initial report: ____/____/____

Location of bird(s):

Address:_____

City _____ State_____ Zip Code_____ County:_____

Date bird was found: ____/____/____ Date bird collected: ____/____/____

Number of birds found dead:_____ Any evidence of trauma: yes no

Species of bird:_____

Date of shipping to the Indiana State Department of Health Laboratory: ____/____/____

Birds should only be submitted for testing if there is no obvious cause of death and if the specimen is fresh (dead for <48 hours). Birds with maggots are not acceptable.

Please enclose this completed form with the dead bird shipment and also FAX the form to: Indiana State Department of Health Laboratory: Attn: Molecular Lab (317) 233-8063.

Please call (317)233-8050 or (317)233-8097 at ISDH with any questions.

Shipping Address:
Indiana State Department of Health Laboratories
Molecular Laboratory Room MS 2023
635 N. Barnhill Drive
Indianapolis, IN 46202-5120

If shipping by U.S Mail
Indiana State Department of Health Laboratories
Molecular Laboratory
PO Box 7203
Indianapolis, IN 46207-7203

ISDH Lab Use Only

ISDH Lab Number:_____ Date Received:_____

Assay Results:_____

Instructions for Collection and Shipment of Bird Carcasses for West Nile Virus Evaluation

Collect sick or freshly dead birds (dead for < 48 hours). Carcasses that are decomposed, maggot infested, or scavenged are usually of limited diagnostic value. Ideally, collect a combination of freshly dead birds and birds that were euthanized after their abnormal behavior was observed and recorded. When possible, take along a cooler containing blue ice or other commercially available cool pack to immediately chill the carcass(es) upon collection. Because WNV attacks the nervous system of crows and other birds; still living, but ill birds, may be unable to fly and may be found on the ground (or possibly struck by a vehicle because the bird was unable to fly properly). **We are not interested in testing any bird found in an area with several dead birds - such a situation would reflect poison exposure.**

Use rubber gloves when picking up dead birds. If you do not have gloves, insert your hand into a plastic bag, pick up bird, and invert bag-allowing hands to remain covered while collecting bird.

Complete a "West Nile Virus Dead Bird Submission Form" for each bird submitted for testing. Additional information can be attached to the form. When possible, FAX a copy of the form(s) to the Molecular Lab (317) 233-8063. **Place submission form in an envelope and tape to the outside of the shipping container.**

If more than one bird is submitted, please uniquely identify each bird and it's corresponding Submission Form. Place each individual bird in a plastic bag with it's unique identification if needed, tie shut, then place inside a second bag and tie shut (more than one individually bagged bird can be placed in the second bag). This system of double bagging prevents cross-contamination of individual specimens and leaking from shipping containers that can contaminate vehicle surfaces and handlers during transportation. Use enough coolant to keep the carcasses cold during shipment. **Do not use wet ice. Do not use dry ice unless instructed to do so.** Place crumpled newspaper or similar absorbent material in the cooler with the bagged carcasses to fill unused space, provide insulation, and absorb any liquids. Tape cooler or box shut with strapping tape. **PLACE ALL PAPERWORK IN AN ENVELOPE AND TAPE TO THE OUTSIDE OF THE SHIPPING CONTAINER.**

When shipping birds in a hard-sided plastic cooler or a Styrofoam cooler, place the cooler in a cardboard box. Unprotected Styrofoam coolers break into pieces during shipment. Stuff newspaper in any space between the sides of the box and cooler. Hard-sided (plastic) coolers will be returned if labeled with your name and address.

Ship Monday through Thursday morning to guarantee arrival at the laboratory before the weekend. If specimens are fresh and need to be shipped on Friday, you must call to make special arrangements.

The laboratory prefers unfrozen specimens if they can be sent within 24 hours of collection or death. Freezing and thawing can damage tissues and make isolation/identification of some pathogens difficult. We will provide guidance on when, or if to freeze, samples on a case by case basis. If you are in the field and cannot call or ship within 24-36 hours, freeze the bird(s).

VIROLOGY/IMMUNOLOGY REQUEST

State Form 35212 (R3/6-03)
CLIA Certified Laboratory #15D0662599

ISDH Lab No. _____

Date Rec'd _____

DATE OF ONSET MUST BE PROVIDED FOR TESTING
SPECIMEN/FORM WITHOUT NAME AND DATE OF COLLECTION WILL NOT BE ANALYZED

Patient's Name _____
(Last) (First) (Middle)

Birthdate _____ Race _____ Sex _____ County _____ Occupation _____

Date of onset ___/___/___ Type of Specimen: _____

Collection Date: ❑ Specimen ___/___/___ Source of Specimen: _____
❑ Acute serum ___/___/___
❑ Convalescent serum ___/___/___

Specific Agent Suspected : _____

LABORATORY EXAMINATIONS AVAILABLE

SEROLOGY

- ❑ Adenovirus
- ❑ Arbovirus (EEE, WEE, SLE, CE, and WNV)
- ❑ Coronavirus (SARS-CoV, Urbani strain)
- ❑ Coxiella (Q-Fever)
- ❑ Ehrlichia
- ❑ Hantavirus
- ❑ Histoplasma
- ❑ Influenza virus
- ❑ Legionella
- ❑ Mumps ❑ IgM ❑ IgG
- ❑ Mycoplasma pneumoniae
- ❑ Parainfluenza virus
- ❑ Respiratory Syncitial Virus (RSV)
- ❑ Rocky Mt. Spotted Fever
- ❑ Rubella ❑ IgM ❑ IgG
- ❑ Rubeola ❑ IgM ❑ IgG
- ❑ Typhus
- ❑ West Nile Virus
- ❑ Varicella (VZV) ❑ IgM ❑ IgG
- ❑ Other_____

CULTURE	**Preferred Source**		**Preferred Source**
❑ Adenovirus		❑ Mumps	
❑ Cytomegalovirus (CMV)		❑ Parainfluenza virus	Nasopharyngeal (NP)
❑ Enterovirus (Coxsackievirus, Echovirus)	Stool	❑ Respiratory Syncitial Virus	
❑ Herpes Simplex (HSV)		❑ Rubella	
❑ Influenza virus	Nasopharyngeal (NP)	❑ Varicella virus (VZV)	
❑ Measles		❑ Other_____	

PCR	**Preferred Source**	
❑ Norovirus	Stool	❑ Other_____
❑ Mycoplasma pneumoniae	Nasopharyngeal (NP)	

SYMPTOMS

General
- ❑ Fever (°)
- ❑ Headache
- ❑ Sore Throat
- ❑ Cough
- ❑ Myalgia
- ❑ Anorexia
- ❑ Otitis
- ❑ Parotitis

Respiratory
- ❑ Common Cold
- ❑ Acute Resp. Distress
- ❑ Bronchitis
- ❑ Pneumonitis
- ❑ Pharyngitis
- ❑ Upper Resp. Infection

CNS
- ❑ Encephalitis
- ❑ Meningitis
- ❑ Neck Rigidity
- ❑ Seizures
- ❑ Paralysis
- ❑ Chorea

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Gastroenteritis

Exanthema
- ❑ Maculopapular
- ❑ Papular
- ❑ Hemorrhagic
- ❑ Vesicular
- ❑ Petechial
- ❑ Erythema Migrans
- ❑ Oral Lesion
- ❑ Genital Lesion

Cardiovascular
- ❑ Myocarditis
- ❑ Pericarditis
- ❑ Endocarditis
- ❑ Cardiomegaly

Ocular
- ❑ Conjunctivitis
- ❑ Chorioretinitis
- ❑ Blurred Vision

Organomegaly
- ❑ Splenomegaly
- ❑ Hepatomegaly
- ❑ Orchitis

Miscellaneous
- ❑ Jaundice
- ❑ Lymphadenopathy
- ❑ Pleurodynia
- ❑ Other_____

State of Illness
- ❑ Symptomatic
- ❑ Asymptomatic
- ❑ Chronic
- ❑ Localized
- ❑ Disseminated

COMPLETE THE INFORMATION ON THE REVERSE SIDE OF THIS FORM

Please Include Species Information and Dates of Contact/Exposure

❑ Contact With And / Or ❑ Exposure To	Insects		Birds	
	Animals		Human Cases	
	Other			

Similar Infection: Family? No ( ) Yes ( ): Or Community? No ( ) Yes ( )

Recent travel? No ( ) Yes ( ) Location/Date: _____

Treatment:	Drugs Used	☐ None	Date Begun (Month/Day/Year)	Date Completed (Month/Day/Year)
	1.			
	2.			
	3.			

Related Immunizations	Month/Year	Recent Vaccinations	Month/Year
1.		1.	
2.		2.	
3.		3.	

Submitting Lab _____

Address _____

_____

Phone _____

Fax _____

Contact Person _____

Physician's Name _____

Address _____

_____

Phone _____

Fax _____

MAILING ADDRESS

Indiana State Department of Health
Virology/Immunology
P.O. Box 7203
Indianapolis, Indiana 46207-7203 Phone (317) 233-8000

SHIPPING ADDRESS (FOR COURIER/DROP-OFF)

Indiana State Department of Health
Virology/Immunology
635 North Barnhill Drive, Room MS2023
Indianapolis, Indiana 46202 Phone (317) 233-8000

SPECIAL INSTRUCTIONS

SEROLOGY/VIRAL ANTIBODY

Submit 3ml serum collected at onset of illness followed by a convalescent serum drawn 2-3 weeks later (3-4 weeks for Legionnaires Disease). Alternatively, hold the acute for the convalescent serum and send together. Use sterile tubes with leak proof screw cap lids.

Serum specimens may be shipped without refrigeration in suitable mailing containers (e.g., ISDH type 9A)

VIRUS CULTURE

Collect specimen for virus culture as early as possible in the acute stage of illness. The usual specimens collected, depending on the virus suspected: NP swabs or throat swabs, stools or rectal swabs, cerebrospinal fluid, effusion fluid, vesicle fluids, lesion swabs or scrapings, biopsy tissue, and postmortem tissues. Use viral transport media for all swabs.

Refrigerate specimens for virus culture immediately after collection. Ship specimens within 24 hours, using ice packs in a heavily insulated box. Pack to prevent breakage or spillage and to conform to shipping regulations.

Freeze specimens for virus culture if they cannot be delivered within 24 hours. Ship frozen specimens on 10 lb. dry ice in a heavily insulated box. **Do not ship on Friday**, hold in freezer for Monday shipping.

MOLECULAR/PCR

Norovirus stool specimens must remain cold from collection to delivery and be delivered within 24 hours of collection. Use container 7A.

Mycoplasma pneumoniae nasopharyngeal (NP) swabs in M4-3 transport media must remain cold from collection to delivery and be delivered within 24 hours of collection.

Ship for overnight delivery. **Do not ship on Friday**. Insulated containers must be enclosed within a cardboard outer shipping container.

RABIES EXAMINATION
Indiana State Department of Health

Rabies Laboratory, Room MS536
Indiana State Department of Health Laboratories
Van Nuys Medical Science Building
635 North Barnhill Drive
Indianapolis, IN 46202 (317) 233-8034

ISDH LAB USE ONLY
LAB NUMBER
ID NUMBER
DATE RECEIVED
DATE REPORTED

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS. This form must be filled out completely and accompany the specimen. Animals that have potentially exposed a person or household pet to rabies will be given priority handling. Exposure is defined as any penetration of skin by the teeth of a potentially rabid animal or contamination of scratches, abrasions, open wounds, or mucous membranes with the saliva or potentially infectious material(such as brain tissue) of a potentially rabid dog.

Sender: Phone Number ( )_____-_____ County where animal is located_____

Name_____ Date of Death of Animal_____

Address_____ Date Shipped_____

City_____State IN ZIP_____ Sender Occupation_____

Kind of animal_____ Identify breed, color making_____

Clinical information regarding the animal
Was animal immunized? ( ) Yes ( ) No ( ) Do not know
Was the animal known to have exhibited any signs and/or symptoms of illness? ( ) Yes ( ) No
If YES, specify_____

Did the animal exhibit any of the following? ( ) convulsions ( ) unusually vicious ( ) unable to eat or drink ( ) excessive salivation ( ) paralysis ( ) noticeable change in behavior_____

Was the animal treated by a veterinarian? ( ) YES ( ) NO If YES, Name and Phone No. _____( )_____

Exposure Information: The Suspected Animal Exposed a: ( ) Human ( ) Animal, specify_____( ) None

Name/Address/Phone Number	Date of Exposure	Type of Exposure
		( ) scratch ( ) bite ( ) handling ( ) other
		( ) scratch ( ) bite ( ) handling ( ) other

Results Notification:
ALL POSITIVE RESULTS WILL BE REPORTED BY TELEPHONE TO THE INDIVIDUAL WHOSE NAME IS LISTED BELOW AND TO THE LOCAL COUNTY HEALTH DEPARTMENT. Please list the name of the individual who will be responsible for arranging treatment of this (these) patient(s) if this should be necessary. You must include telephone numbers where this individual can be reached during working hours, after working hours, and on weekends. The State does not supply or administer the prophylaxis for rabies. By State Communicable Disease Reporting Rule, "Every case of a human bitten by a domestic or wild animal shall be reported promptly to the Local Health Officer having jurisdiction 410 IAC 1-2.1).

Name_____ Telephone (9 am to 4:30 PM) ( )_____

After 4:30 PM and weekends ( )_____

ALL NEGATIVE RESULTS WILL BE MAILIED TO THE SENDER. ALL POSITIVE RESULTS WILL ALSO BE TELEPHONED TO THE SENDER.

DO NOT WRITE BELOW THIS LINE-FOR LAB USE ONLY

FLUORESCENT ANTIBODY TEST RESULTS

_____Negative _____Positive _____Unsatisfactory _____Decomposed ( )_____

RESULTS TELEPHONED: Date_____ Time_____ Reported To:_____

Copies to: ( ) Communicable Disease ( ) Local Health Department Microbiologist:_____

State Form 37763 (R6/6-04)

SENDER NOTE: NOTIFY PATIENT OF RESULTS

Indiana State Department of Health

INSTRUCTIONS FOR THE SUBMISSION OF ANIMAL HEADS AND BATS RABIES FOR TESTING

SPECIMEN

Since brain tissue is examined for the diagnosis of rabies, only the animal head will be accepted for diagnostic purposes. Animals should be euthanized in a manner that will not destroy the brain. The neck should be severed at the mid-point between the base of the skull and shoulders. For bats, the whole dead animal should be submitted. Brain material from animals with central nervous disease symptoms may be submitted by veterinarians or veterinary diagnostic laboratories as part of their diagnostic process without regard to bite or other exposure status. Only fresh, non-fixed tissue is acceptable. A negative finding for rabies can be made only if a complete cross section of the brain stem is examined. Examination may be made at the level of the pons, medulla or midbrain. All rabies specimens must be properly packaged before delivery to the ISDH Laboratories.

COMPLETION OF FORM

Complete the sections labeled **Sender, Clinical Information regarding the animal, Exposure information,** and **Results Notification,** on the front of the specimen submission form. Seal the form in a separate plastic zip-lock bag and enclose with the specimen. An incomplete form may result in the delay of conveying vital information to the person or persons exposed.

PACKAGING OF SPECIMENS

Place animal head specimens for rabies diagnosis in a leak proof container (e.g. double bag using heavy duty plastic bags) and seal tightly. Place this container in an insulated shipping carton and enclose a sealed refrigerant pack to keep the specimen cold. **DO NOT USE WET ICE.** The use of sealed cold packs eliminates the problem of the refrigerant leaking from the shipping container. Specimens should be kept cold, but preferably not frozen. Freezing the head will delay testing since it may take up to 24 hours to thaw, it also damages the tissue.

SHIPMENT OF SPECIMENS

Shipment via commercial bus or courier service is usually the most rapid method of delivery. An ISDH staff person picks up specimens shipped by bus 7 days per week. The US Post Office will not accept this type of specimen for mailing. As of the time of this printing, United Parcel Service (UPS) will accept specimens for delivery to us if properly packaged. Consult with your local UPS representative to obtain the most current shipping/packaging requirements for UPS. Use the address on the front of this form for shipping specimens.

PERSONAL DELIVERY OF SPECIMENS

It is also possible for individuals to hand carry properly packaged specimens to the ISDH Laboratories between the hours of 8:30AM and 4:30PM (M-F) except for State recognized holidays. Bring the specimens to room MS2023 at the above address. Personal delivery after hours, weekends, or holidays must be taken to the IUPUI Campus Police building located at the Ball Residence Building at 1232 West Michigan Street. Directions and/or map to either location may be obtained by contacting the ISDH Laboratories at 317-233-8000 or at the ISDH Web site.

REPORTING OF RESULTS

Positive rabies test results will be reported immediately by telephone to both the Local Health Department officials and to the individual identified for Results Notification. Negative test results will routinely be reported by mail.

MAMMALS IN THE ORDER RODENTIA

These mammals include squirrels, rats, mice, guinea pigs, hamsters, gerbils, beavers, moles and voles. They are rarely rabid in the United States, and should be submitted for rabies testing only under exceptional circumstances. Consult you Local Health Department when rodents or lagomorphs are involved.

CONTACTS FOR FURTHER INFORMATION

For questions concerning suspected rabies incidents involving possible human exposure, contact James Howell, DVM, ISDH Veterinary Epidemiologist at 317-233-7272. For questions concerning suspected rabies incidents involving possible domestic animal exposure, contact Sandra Norman, DVM, Indiana Board of Animal Health at 317-227-0323. For general laboratory questions, contact the ISDH Laboratories at 317-233-8034.

CHLAMYDIA / GONORRHEA / SYPHILIS REQUEST FORM

INDIANA STATE DEPARTMENT OF HEALTH LABORATORIES

MICROBIOLOGY / VIROLOGY-IMMUNOLOGY

635 North Barnhill Drive, P.O. 7203, Indianapolis, IN 46207-7203 · (317) 233-8000

INSTRUCTIONS

1. Print firmly and neatly.
2. Only use pens with medium point black ink.
3. Fill-in circles like this: ● **Not** like this: ⊗ ✓ Mark mistakes like this: ✱
4. Print capital letters only and numbers completely inside boxes: A B C 3
5. Please complete all items on form.

PATIENT INFORMATION

PATIENT'S CLINIC ID NUMBER

PATIENT'S FIRST NAME MI

PATIENT'S LAST NAME

STREET ADDRESS

CITY STATE

ZIP CODE FIPS CODE MEDICAID NUMBER

DATE OF BIRTH

MONTH	DAY	YEAR
○ JAN	00	0000
○ FEB	11	1111
○ MAR	22	2222
○ APR	33	3333
○ MAY	4	4444
○ JUN	5	5555
○ JUL	6	6666
○ AUG	7	7777
○ SEP	8	8888
○ OCT	9	9999
○ NOV		
○ DEC		

SEX/GENDER

- ○ MALE
- ○ FEMALE

PATIENT'S SELF REPORTED RACE

- ○ NATIVE AMERICAN
- ○ ASIAN/PACIFIC ISLANDER
- ○ PACIFIC ISLANDER/HAWAIIAN
- ○ AFRICAN AMERICAN/BLACK
- ○ WHITE/CAUCASIAN
- ○ OTHER
- ○ UNKNOWN

HISPANIC ETHNICITY?

- ○ YES
- ○ NO
- ○ UNKNOWN

SPECIMEN INFORMATION

COLLECTION DATE

MONTH	DAY	YEAR
○ JAN	00	0000
○ FEB	11	1111
○ MAR	22	2222
○ APR	33	3333
○ MAY	44	4444
○ JUN	55	5555
○ JUL	66	6666
○ AUG	77	7777
○ SEP	88	8888
○ OCT	99	9999
○ NOV		
○ DEC		

SOURCE OF SPECIMEN

(Choose Only One)

- ○ FEMALE / CERVIX
- ○ MALE / URETHRA
- ○ URINE
- ○ BLOOD/SERUM

REASON FOR TEST

(Choose All That Apply)

- ○ < 25 YEARS OF AGE
- ○ SYMPTOMS/SIGNS
- ○ CONTACT TO STD
- ○ SEX PARTNER RISK
- ○ HX of STD
- ○ CONTRACEPTION
- ○ PRENATAL
- ○ NON-PROTOCOL TESTING CT/GC
- ○ SYPHILIS SCREENING
- ○ SYPHILIS FOLLOW UP

TEST TYPE

(Choose Only One)

- ○ CT/GC
- ○ SYPHILIS SCREENING
- ○ SYPHILIS CONFIRMATORY

CLINIC INFORMATION

PROVIDER CODE

STAFF ID

INITIALS OF PERSON FILLING FORM

Clinic Name:

FOR LAB USE ONLY

UNSAT SPECIMEN

- ○ NO DOC ON TUBE
- ○ NO SWAB
- ○ IMPROPER SWAB
- ○ NO SPECIMEN
- ○ IMPROPER SOURCE
- ○ HEMOLYZED
- ○ NO ID ON SPECIMEN
- ○ EXPIRED TRANSPORT SYSTEM
- ○ QUANTITY NOT SUFFICIENT
- ○ ID MISMATCH
- ○ NO FORM
- ○ OTHER _____

SPECIMEN NUMBER

RECEIVED DATE

Indiana State Department of Health Laboratory
Chlamydia/Gonorrhea/Syphilis Submission Form

Chlamydia/Gonorrhea Specimen Collection:

1. Follow exactly the instructions that are on the GenProbe Aptima Combo 2 Assay Unisex Specimen Collection Kit. **Use only the swabs and the transport tube that are with the of kit. Do not use expired transport tubes.**
2. For female endocervical specimens: Use the white shaft cleaning swab to remove excess mucus from cervical os and discard. Use the blue shaft swab to collect the specimen. Insert swab into the endocervical canal, rotate clockwise for 10-30 sec, remove carefully and place swab into the transport tube. Carefully break the swab shaft at the scoreline.
3. For male urethral specimens: Use the blue shaft swab to collect the specimen. Insert swab 2-4 cm into the urethra, rotate for 2-3 sec, remove carefully and place swab into the transport tube. Carefully break the swab shaft at the scoreline.
4. Make sure the cap is tightly secured to the tube.
5. Label tube with patient name and date of collection. Use writing implements that do not smear. Specimens without a patient ID and collection date will be considered unsatisfactory and will not be tested.
6. Insert only the transport tube(s) in the mailing container, wrap the requisition form(s) around the **outside** of the container and place the container inside a 1st Class envelope.
7. Mail the specimen(s) at room temperature. Specimen(s) must arrive at our facility within 60 days of collection.

Syphilis Specimen Collection:

1. Submit at least 3ml of serum in the sterile plastic screw-capped vial provided in the mailing container. Alternatively, collect 7-10 ml of blood in a red-topped venipuncture or serum separator tube. Label the specimen with the patient identifier and collection date. Use writing implements that do not smear. Specimens without a patient ID and collection date will be considered unsatisfactory and will not be tested.

Syphilis Specimen Packaging and Shipment:

1. Use container 5B provided by ISDH for shipping serum or blood specimens.
2. Wrap the absorbent material, provided inside the inner mailing container, around the specimen tube to absorb inner shock and contain possible leakage. Insert the wrapped sample tube into the inner-mailing container. Secure cap tightly. Place the completed requisition between the inner and outer mailing container.
3. Complete the pre-addressed label on the outer mailing container with a return address and postage, and send via first class US mail.
4. Please use above packaging instructions to assure compliance with federal shipping regulations and to minimize breakage. Broken or leaking specimens present a biohazard and can not be tested.
5. Specimens submitted by courier should be packaged securely to prevent breakage. Loose specimens in Ziploc bags increase the chance of breakage and biohazard exposure.

Form Completion:

1. Only the original form may be used. **Photocopies of the form are not allowed**.
2. Information for only one specimen must be on the form.
3. **All** items on form must be completed in order to process the specimen.
4. The circles must be completely filled using medium point black ink.
5. The boxes must be completed using capital letters and/or numbers.
6. Keep the letters and numbers within the box. **DO NOT** allow the letters or numbers to extend outside of the box or touch the lines.
7. The **test type must be selected**: GC= N. Gonorrhoeae; CT= C. trachomatis
8. Do not fill out any information in the "FOR LAB USE ONLY" area.

DIRECT QUESTIONS TO: 317-233-8000

28025

HIV SEROLOGY

INDIANA STATE DEPARTMENT OF HEALTH LABORATORIES
VIROLOGY-IMMUNOLOGY 635 NORTH BARNHILL DRIVE
PO BOX 7203 INDIANAPOLIS IN 46207-7203 · (317) 233-8050

INSTRUCTIONS:

1. Print firmly and neatly.
2. Only use pens with medium point black ink.
3. Fill-in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✱
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.

PATIENT INFORMATION:

OPSCAN NUMBER OR CONFIDENTIAL ID

DATE OF BIRTH (MO/DY/YR) / /

AGE

SEX/GENDER M ○ F ○ UNK ○

PATIENT FIRST NAME **MI**

PATIENT LAST NAME

RACE
○ NATIVE AMERICAN ○ WHITE/CAUCASIAN ○ OTHER/UNKNOWN
○ ASIAN/PACIFIC ISLANDER ○ AFRICAN AMERICAN/BLACK

NUMERIC COUNTY OF RESIDENCE CODE

SPECIMEN INFORMATION:

TYPE OF SPECIMEN
○ BLOOD ○ ORAL FLUID
○ SERUM ○ NEWBORN SERUM
○ PLASMA ○ NEWBORN BLOOD

DATE OF COLLECTION (MONTH / DAY / YEAR) / /

AFRICAN OR CONTACT WITH AFRICANS Y ○ N ○

PARTICIPANT IN VACCINE TRIAL Y ○ N ○

IS THIS THE FIRST SPECIMEN FOR THIS PERSON? Y ○ N ○

TYPE OF CLINIC
○ COUNSELING AND TESTING SITE
○ PHYSICIAN
○ DEPARTMENT OF CORRECTION INSTITUTION
○ DEPARTMENT OF MENTAL HEALTH
○ OTHER (SPECIFY BELOW)

PLACE OPSCAN LABEL INSIDE BOX

DATE OF PRIOR SUBMISSION: / /

PREVIOUS OPSCAN NUMBER:

PREVIOUS ISDH LAB NUMBER:

CLINIC INFORMATION:

FACILITY

ADDRESS

CITY **STATE** **ZIP CODE** **FACILITY NUMBER**

FOR ISDH LAB USE

UNSATISFACTORY
○ QNS
○ HEMOLYZED
○ LEAKED IN TRANSIT
○ LOST IN TRANSIT
○ NO NAME ON TUBE
○ OTHER:_____

DATE RECEIVED

_____

28025

State Form 29405 (R5 / 10-99) **DO NOT DUPLICATE -- PHOTOCOPIES ARE UNACCEPTABLE**

HIV SEROLOGY

INTENDED USE:

The Retrovirology Laboratory utilizes the enzyme immunoassay (EIA;ELISA) method for the detection of antibodies to HIV-1/2 in serum and HIV-1 in oral fluid (mucosal transudate). All initially Reactive specimens are automatically repeated. Repeatedly reactive specimens are further tested using a qualitative immunoblot assay for the detection and identification of antibodies to individual proteins of HIV-1. Serum or oral fluid specimens testing negative on EIA/ELISA are reported out as NO ANTIBODY TO HIV-1 DETECTED. Serum or oral fluid specimens testing repeatedly reactive on EIA/ELISA and confirmed POSITIVE on Western Blot are reported out as ANTIBODY TO HIV-1 HAS BEEN DETECTED AND CONFIRMED BY WESTERN BLOT FOR THIS SPECIMEN. A follow-up specimen is recommended to VERIFY the POSITIVE. Serum or oral fluid specimens testing repeatedly reactive on EIA/ELISA and show any viral bands on the Western Blot but which does not meet the criteria for a POSITIVE are reported out as INDETERMINATE. A follow-up specimen is strongly recommended 6 weeks to 6 months from the original specimen collection date. Oral fluid specimens testing repeatedly reactive on EIA/ELISA and negative on Western Blot are reported out as NO ANTIBODY TO HIV-1 DETECTED. Serum specimens testing repeatedly reactive on EIA/ELISA and negative on Western Blot are reported out as INCONCLUSIVE. A follow-up specimen is strongly recommended 6 weeks to 6 months from the original specimen collection date. Turnaround time is a maximum of 7 working days.

SEROLOGICAL OR ORAL SPECIMEN COLLECTION:

1. Submit at least 3ml of serum in the sterile plastic screw-capped vial provided in the mailing container. Alternatively, collect 7-10 ml of blood in a red-topped venipuncture or serum separator tube. Label the specimen with the patient identifier and collection date. Use writing implements that do not smear. Specimens without a patient ID and collection date will be considered unsatisfactory and will not be tested.

2. Collect oral fluid specimen using OraSure HIV-1 Oral Specimen Collection Device following manufacturer's recommendations. Label the specimen with the patient identifier and collection date. Use writing implements that do not smear. Specimens without a patient ID and collection date will be considered unsatisfactory and will not be tested. At this time, oral fluid testing is available to only selected facilities. Call the laboratory for additional information.

3. Complete this form on the reverse side in ink. The submitter address to which the results are to be sent, including ZIP code and Facility Number, must be included, as well as the type of specimen sent. Any incomplete information will cause significant delays in receiving results. Final reports will be forwarded only to the listed submitter within the Facility Number block. Call the laboratory for your Facility Number if one was not previously assigned.

SPECIMEN PACKAGING AND SHIPMENT:

1. Use container 1A provided by ISDH for shipping serum or oral fluid specimens. Use container 1B for shipping red-topped or serum separator tubes.

2. Wrap the absorbent material, provided inside the inner mailing container, around the specimen tube to absorb inner shock and contain possible leakage. Insert the wrapped sample tube into the inner-mailing container. Secure cap tightly. Place the completed requisition between the inner and outer mailing container.

3. Complete the pre-addressed label on the outer mailing container with a return address and postage, and send via first class US mail.

4. Please use above packaging instructions to assure compliance with federal shipping regulations and to minimize breakage. Broken or leaking specimens present a biohazard and can not be tested.

5. Specimens submitted by courier should be packaged securely to prevent breakage. Loose specimens in Ziploc bags increase the chance of breakage and biohazard exposure.

DIRECT QUESTIONS TO: 317-233-8050

VERSION 02/16/00

56356

HEPATITIS SEROLOGY

INDIANA STATE DEPARTMENT OF HEALTH LABORATORIES
VIROLOGY-IMMUNOLOGY 635 NORTH BARNHILL DRIVE
PO BOX 7203 INDIANAPOLIS IN 46207-7203 (317) 233-8050

INSTRUCTIONS:

- Print firmly and neatly. Only use pens with medium point black ink.
- Fill-in circles like this: ● **Not** like this: ⊗ ✓ Mark mistakes like this: ✖
- Print capital letters only and numbers completely inside boxes. A 2 C 3
- Please complete all items on form.

PATIENT INFORMATION:

PATIENT FIRST NAME | **MI** | **SEX/GENDER** ○ MALE ○ FEMALE

PATIENT LAST NAME | **AGE**

RACE
- ○ NATIVE AMERICAN
- ○ ASIAN/PACIFIC ISLANDER
- ○ AFRICAN AMERICAN/BLACK
- ○ WHITE/CAUCASIAN
- ○ OTHER/UNKNOWN

SPECIMEN INFORMATION:

COLLECTION DATE

MONTH	DAY	YEAR
○ JAN	0 0	0 0 0 0
○ FEB	1 1	1 1 1 1
○ MAR	2 2	2 2 2 2
○ APR	3 3	3 3 3
○ MAY		4 4 4
○ JUN		5 5 5
○ JUL		6 6 6
○ AUG		7 7 7
○ SEP		8 8 8
○ OCT		9 9 9
○ NOV		
○ DEC		

SELECT HEPATITIS TESTS REQUESTING
- ○ HEPATITIS A
- ○ HEPATITIS B
- ○ HEPATITIS C
- ○ HEPATITIS A & B
- ○ HEPATITIS B & C
- ○ HEPATITIS A & C
- ○ HEPATITIS A, B & C
- ○ HEPATITIS INFECTIOUS DISEASE PANEL (Suspected cases only - not for screening)

REASON FOR TEST
- ○ RECENT INFECTION
- ○ EXPOSURE TO RECENT INFECTION
- ○ OUTBREAK INVESTIGATION
- ○ SUSPECTED CARRIER
- ○ PATIENT IMMUNE STATUS
- ○ STAFF IMMUNE STATUS

DATE OF ONSET

MONTH	DAY	YEAR
○ JAN	0 0	0 0 0 0
○ FEB	1 1	1 1 1 1
○ MAR	2 2	2 2 2 2
○ APR	3 3	3 3 3
○ MAY		4 4 4
○ JUN		5 5 5
○ JUL		6 6 6
○ AUG		7 7 7
○ SEP		8 8 8
○ OCT		9 9 9
○ NOV		
○ DEC		

CLINIC INFORMATION:

FACILITY

ADDRESS

CITY | **STATE** | **ZIP CODE** | **FACILITY NUMBER**

FOR ISDH LAB USE

HBsAg	○ POSITIVE	○ NEGATIVE	○ UNSAT	**ANTI-HBe**	○ POSITIVE	○ NEGATIVE	○ UNSAT
ANTI-HBs	○ POSITIVE	○ NEGATIVE	○ UNSAT	**ANTI-HAV**	○ POSITIVE	○ NEGATIVE	○ UNSAT
ANTI-HBc	○ POSITIVE	○ NEGATIVE	○ UNSAT	**ANTI-HAV IgM**	○ POSITIVE	○ NEGATIVE	○ UNSAT
ANTI-HBc IgM	○ POSITIVE	○ NEGATIVE	○ UNSAT	**ANTI-HCV**	○ POSITIVE	○ NEGATIVE	○ UNSAT
HBe	○ POSITIVE	○ NEGATIVE	○ UNSAT	**RIBA HCV 2.0**	○ POSITIVE	○ NEGATIVE	○ UNSAT

UNSATISFACTORY SPECIMEN
- ○ QNS
- ○ HEMOLYZED
- ○ LEAKED IN TRANSIT
- ○ LOST IN TRANSIT
- ○ NO NAME ON TUBE
- ○ OTHER:_____

RECEIVED DATE / /

COMMENTS:_____

REPORTING MICROBIOLOGIST

FINAL REPORT DATE

☐ Copy to Communicable Disease Program

State Form 45002 (R5/5-00)

Information confidential pursuant to IC 16-41-8-1 and IC 16-39

DO NOT DUPLICATE -- PHOTOCOPIES ARE UNACCEPTABLE

HEPATITIS SEROLOGY

INTENDED USE:

The Immunology Laboratory utilizes the enzyme immunoassay (EIA; ELISA) method for detecting antigens and antibodies to hepatitis A, B and C in serum. Hepatitis infectious disease panel testing includes Anti-HAV IgM, HBsAg, Anti-HBc IgM, and Anti-HCV markers. Specimens submitted for hepatitis A testing are initially screened for Anti-HAV total antibody. Reactive specimens are then tested further for Anti-HAV IgM. Specimens submitted for hepatitis B testing are tested initially for HBsAg, Anti-HBs, and Anti-HBc. Specimens confirmed positive for HBsAg are then tested further for Anti-HBc- IgM, HBeAg, and Anti-HBe markers. Specimens submitted for hepatitis C testing are screened for Anti-HCV total antibody. An HCV supplemental immunoblot assay is performed on all repeatedly reactive specimens. When necessary, an initially reactive specimen is automatically repeated, and repeatedly reactive specimens are reported as positive. Turnaround time is a maximum of 11 working days. Normal ranges are negative. **Hepatitis infectious disease panel and Hepatitis A testing will be performed only if a DATE of ONSET is given.**

SEROLOGICAL SPECIMEN COLLECTION:

1. Submit at least 3 ml of serum in the plastic screw-capped vial provided in the mailing container. Alternatively, collect 7-10 ml of blood in a red-topped venipuncture tube. Label the specimen tube with the patient identifier and collection date. Use writing implements that do not smear. **Specimens without a patient ID will be considered unsatisfactory and will *not* be tested.**
2. Complete this form on reverse side in ink. **The submitter address to which the results are to be sent, including ZIP code, *must* be included, as well as the requested test type.** Any incomplete information will cause significant delays in receiving results. A copy of this report will be forwarded only to the listed submitter within the return address block.

SPECIMEN PACKING AND SHIPMENT:

1. Use the containers 11B provided by ISDH for shipping specimens.
2. Wrap the absorbent material, provided inside the inner mailing container, around the specimen tube to absorb inner shock and contain possible leakage. Insert the wrapped sample tube into the inner mailing container. Secure cap. Wrap completed request form around the inner mailing container and place into the outer mailing container. Secure cap tightly.
3. Complete the pre-addressed label on the outer mailing container with a return address and postage, and send via first class US mail.
4. Please use above packaging instructions to assure compliance with federal shipping regulations and to minimize breakage. Broken or leaking specimens present a biohazard and cannot be tested.
5. Specimens submitted by courier should be packaged securely to prevent breakage. Loose specimens in Ziploc bags increase the chance of breakage and biohazard exposure.

DIRECT QUESTIONS TO: 317-233-8050

VERSION 04/20/01

Perinatal Hepatitis B Screen

SF 45057 (R5/9-01)

Indiana State Department of Health
Virology – Immunology
635 N. Barnhill Drive, Room MS 2023
P.O. Box 7203
Indianapolis, IN 46207-7203
(317) 233-8050

This questionnaire is authorized by IC 16-19-3-1 and 42 USC247(b). Although response is voluntary, cooperation is necessary for the study and control of the disease. This information is confidential pursuant to IC 16-41-8-1 and IC 16-39

PATIENT INFORMATION

Patient's Last Name First Middle

Patient's Address

City County State Zip

FOR ISDH USE ONLY

ISDH Lab No. _____

Date Received _____

High Risk

DOB	Race	Ethnicity	Sex	Telephone ( )	Estimated Date of Confinement	Date Specimen Collected

PATIENT HISTORY ***(complete only for prenatal patients)***

Refugee ❑ Yes ❑ No ISDH Lab. No._____

Specimen This Pregnancy ❑ First ❑ Second ❑ Other _____

HBV Immunization ❑ Yes ❑ No Date(s)_____ (Previous Specimen)

Diagnosed acute HBV infection during current pregnancy?	Yes	No	Unknown
Trimester diagnosed: ❑ First ❑ Second ❑ Third ❑ Post-Delivery			
Past diagnosed HBV infection?	Yes	No	Unknown
Current symptoms of hepatitis?	Yes	No	Unknown
Past acute/chronic liver disease?	Yes	No	Unknown
Past transfusion or hemodialysis?	Yes	No	Unknown
Past or current use of IV drugs?	Yes	No	Unknown
Past or current sexual contact with IV drug users?	Yes	No	Unknown
Past or current sexual contact with greater than 1 partner in the last 6 months?	Yes	No	Unknown
More than one episode of STD?	Yes	No	Unknown
Past or current health care employment with exposure to blood/body fluids?	Yes	No	Unknown
Past or current work in residential institutions for mentally handicapped persons?	Yes	No	Unknown
Past or current sexual/household contact with HBV patient/carrier?	Yes	No	Unknown

Country of Origin: _____

CONTACT HISTORY (complete only for contacts of prenatal positive patients)

Relationship to prenatal patient: ❑ Immunized infant born to prenatal positive mother
❑ Household/sexual contact (including other children)

Name of prenatal patient:

DR's Name _____

Address _____

City _____ State _____ Zip _____

County _____ Office Phone (_____)_____

FOR ISDH USE ONLY

LABORATORY RESULT

DATE:_____

HbsAg (EIA) ❑ Positive ❑ Negative

Anti-HBs (EIA) ❑ Positive ❑ Negative

Anti-HBc (EIA) ❑ Positive ❑ Negative

Comments_____

PERINATAL HEPATITIS B SCREENING PROGRAM

INTENDED USE

The purpose of this program is to screen pregnant women in the state of Indiana for the hepatitis B virus. One serum sample should be collected from each patient as early as possible in the pregnancy for laboratory testing at the ISDH. Additional samples may be required if initial results are positive or if the patient is at high risk of infection. In addition, contacts of seropositive women will be screened.

SEROLOGICAL SPECIMEN COLLECTION

1. Collect 5-10 ml of blood in a serum-separator tube with a tight-fitting cap and label with patient name and collection date. Use writing implements that do not smear.

2. Complete this form on reverse side in ink, including 9-digit zip code, with each properly labeled specimen.

PACKING AND SHIPPING SPECIMENS

1. Use container 11C provided by the ISDH for shipping specimens.

2. Wrap the absorbent material, provided inside the inner mailing container, around the specimen tube to absorb shock and contain possible leakage. Insert wrapped sample tube into inner mailing container. Secure cap. Wrap completed request form around inner container and place in outer mailing container. Secure cap tightly.

3. Complete the pre-addressed label on outer mailing container with a return address and postage, and send via first class US mail.

4. Please use above packaging instructions to assure compliance with federal shipping regulations and to minimize breakage. Broken or leaking specimens present a biohazard and cannot be tested.

Treponemal Syphilis Test Request

State Form 13708 (R7/12-03)
CLIA #15D0662599

Date Received/ISDH Lab Number

Indiana State Department of Health
Clinical Microbiology
P.O. Box 7203
635 N. Barnhill Drive
Indianapolis, IN 46207-7203
(317) 233-8048

SEND REPORT TO:

Last Name	First Name	M
Patient:		

( )Application for a MARRIAGE LICENSE_____STATE

( ) Prenatal ( ) Diagnostic Aid ( ) Control of Treatment ( ) Screening

Age	Race	Sex	Signs of Syphilis?	Type of Specimen
			( ) Yes ( ) No	( ) Blood ( ) CSF

Date of Onset	Test Requested	Date Specimen Collected

EVIDENCE OF CONDITIONS OTHER THAN SYPHILIS

( ) Infectious Mononucleosis ( ) Any Viral Disease ( ) Drug Abuse

( ) Collagen Disease ( ) Recent Immunizations ( ) Other

SUBMITTER COMMENTS

DO NOT CUT FORM

Syphilis Serology
Specimen Submission Instructions
(ISDH Container No. 5B – Syphilis)

Submit at least 0.5 ml of serum/spinal fluid or at least 1.0 ml of whole blood in a vacutainer tube. Label the tube with the patient's name or ID number and specimen collection date. Enclose specimen in the metal container. Fold and wrap the completed request form around the metal container and place both into the outer mailer. Affix first class postage and mail promptly to our laboratory. Do not mark anything in the "RESULTS" box on the submission form. During handling, do not store specimen(s) at temperature below 4°C or higher than ambient.

Submitted specimens are screened by the Venereal Disease Research Laboratory (VDRL) test. Those that test "weakly reactive" or "reactive" are specifically confirmed by the Fluorescent Treponemal Antibody (FTA) procedure.

DO NOT WRITE BELOW THIS LINE

RESULTS

VDRL ( ) Reactive 1:_____ ( ) Weakly Reactive ( ) Negative Microbiologist_____ Date Reported_____

FTA ( ) Reactive ( ) Reactive Minimal ( ) Negative Unsatisfactory Due to: ( ) Hemolysis ( ) Quantity Not Sufficient

( )_____

LABORATORY COMMENTS

( ) Copy to HIV_STD